2017 NCSBN Annual Meeting - The Next Era of Regulation: Partnerships for Change Video Transcript
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Event
2017 NCSBN Annual Meeting

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Presenter
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Just as an aside, David mentioned that I served as the Acting Deputy Secretary for the US Department of Health and Human Services. And he also said that he hoped that it wouldn't be the last time that a nurse would serve in this capacity. That's true. I am the first nurse to have served as the Acting Deputy Secretary. But in my mind, throughout that entire position, I just want all of you to know that I wanted to do so well in that job as a nurse, that nurses would be automatically considered as perfect professionals to serve in that capacity in future administrations. So there's no question in my mind that I might be the first, but I am not the last by a long shot, David. Thanks so much, though, for that great introduction. And also, good morning everyone? I want to say on the front end that it's just a pleasure to be here with all of you. Before, though, I turn your attention to the topic at hand, I want to take a moment to express my thanks, my thanks to each of you for the incredibly important work that you do. The collective contributions that boards of nursing make are so important in helping to ensure that the nursing care to the public, the nursing care that the public receives every minute, every hour, every day is safe care delivered by competent nurses. As regulators of nursing, whether you're a board executive, you're board staff, or a board member, your work tends to be often largely unseen by the public. The work you do is probably not often thought about even by the people you regulate, except for those discreet touch points. For example, when documentation and fees are needed for one to continue their professional licensure, or when recent graduates sit for licensing exams, or when you're queried about a particular provider. Even when you promulgate new rules, regulations, or you revamp an old one, information about your work does not always resonate broadly. But the impact of it does. It does resonate. So I think it's important to step back and acknowledge that what is going on right now in the delivery of nursing care, in health facilities, in patient homes, and in many other places, from right here in Chicago to across the nation and through NCSBN's leadership to influencing nursing care that is delivered in other countries around the world. What happens in the delivery of nursing care is influenced and it is shaped by you. And from state to national, to international levels, you have some terrific accomplishments to point to. As recently as NCSBN's testimony, just a few weeks ago, before an FTC committee looking at occupational licensing reform, Kathy Thomas's discussion of your innovative work around licensure across multiple states elevated the visibility of nursing boards as producers of innovations in health care. The contributions of boards of nursing are substantive. And so as I said,
thanks. Thanks to each of you for the leadership and for the important service that you provide. And special thanks to the leadership of NCSBN for providing the infrastructure to drive forward an agenda that supports the delivery of safe, competent nursing care, not just in the United States, but in partnership with counterparts around the world. Having said that, as Will Rogers once said, "Even if you're on the right track, you'll get run over if you just sit there." Not that any one of you in this room right now would intentionally just sit there, but because of the environment that you're operating in, leaning into this next era of health care requires more and different strategies from health care regulators and virtually every other healthcare stakeholder. It requires redoubling your efforts to develop and strengthen robust partnerships and collaboration to achieve your aims. As you will hear throughout my remarks, partnerships and substantive collaboration are increasingly central to efforts designed to shape healthcare, including improving and sustaining care quality broadly and patient safety specifically. Today, I'm going to share five observations with you or takeaways, if you will, to consider about building partnerships. And I'll provide an example or two to illustrate the relevance of each one of those five observations. Before I talk about shifts underway across the healthcare landscape that are driving this need for collaboration, there is one related dynamic that I want to comment on. And it comes from outside of healthcare delivery, but it impacts healthcare and so it impacts your work as well. And that is the activity and attitude around regulations generally. Like healthcare, the regulatory environment itself, the boards of nursing and other regulatory bodies operate in, it's being reshaped too, although for different reasons. In other words, there are shifts occurring in the regulatory environment that wraps around you, even as the features of what you are regulating, nursing within the larger healthcare ecosystem are changing. And changes in the regulatory environment can impact both what you do, that affects nursing and healthcare, and how you do it. So let's step back for just a minute to consider this broader regulatory context that can impact your work and then I'll move on to talk about collaboration across this changing healthcare environment. Since the change in administration at the federal level this past January, there has been a substantial shift in regulatory activity and how it's viewed. The Trump administration views regulatory activity differently from the Obama administration. This contrast is most evident, as you are aware, in the current administration's fairly comprehensive efforts to...just lost my place and should put my glasses on...in the current administration's comprehensive efforts that are underway across cabinet agencies to freeze and to roll back a number of regulations. These are regulations that impact a range of industries and issues, from the banking industry to the healthcare industry to the environment. Related to this is the expectation from the White House now that for every regulation that is promulgated, two rules must be either repealed or revised. Before the Trump administration, the Obama administration was also working to remove what we viewed as outdated and problematic regulations. But the scale of effort and the focus of those efforts was really quite different between these two administrations. I know this because as Acting Deputy Secretary, I was responsible for overseeing most of the HHS regulatory efforts, including regulatory reform. At the state level, shifts in how regulatory activity is viewed, of course, can also occur and that changes as political leadership changes, in governor's offices and state legislatures. Many of the nursing boards' executives in this room that have been around for a while are aware of these kinds of changes and they've probably even seen them firsthand. The difference in how regulation is perceived as a tool of public policy is not unexpected because policy approaches and priorities, both at the state level and federal level as well, are often tied to the political orientation and agendas of the parties in power, at state and federal levels. In other words, Democrats versus Republicans or Republicans versus Democrats controlling state houses, the White House, state legislatures, or the US Congress. They have a view of the tools of government differently, and even the role of government, a bit differently. In fact, calling attention to these important distinctions, your Associate Director of State Advocacy and Legislative Affairs points out in an article
that she authored, titled *Regulating Certified Professional Midwives,* that Republican control of state legislation translates to increased attention to deregulation and to increased competition. That deregulation effort, at the federal level, is playing out fairly rapidly now. Let me give you one concrete example that illustrates the difference in approaches. The Affordable Care Act drove substantial changes in health care, much of it through promulgating new regulations. The overarching aim was to serve the health and health care needs of Americans better by improving access and health care quality and decreasing the rate of growth in spending on health. Through regulatory activity in the Obama administration, far-reaching changes in health care infrastructure occurred, ranging from changes in payment policy to changes in primary care. For example, moving away from fee-for-service payment to new payment models that paid for care quality rather than quantity of services provided. These payment strategies were designed to pivot away from fragmented and piecemeal care to payment policies that would support the delivery of comprehensive care. In the process, HHS staff worked with outside stakeholders to ensure that they had the best thinking, data and also through collaboration, some buy-in from organizations that would be impacted. Because we recognize that this major shift was complex and would have a high impact on health care providers. These payment changes would require new metrics, new priorities, and even a new orientation in the way that health care is delivered. As I mentioned, when administrations change, not uncommonly, priorities and the solutions selected to address those priorities also often typically change. So underway now is a change. Inside HHS and other cabinet agencies too, are some new regulatory review processes that have been established to evaluate the scope of specific regulations and determine whether the substance of those regulations that are on the books right now are essential to meeting the letter of a law or, alternatively, could be scaled back. So it's a difference in perspective between two administrations. So staying with my earlier example, the Trump administration now is looking at payment policies. One of the key areas that is being revisited, and looking specifically at regulations, some that could be rolled back to accommodate, again, different priorities, different solutions. So as we think about change in healthcare, we think about it over a time frame. Over the past seven years roughly, a lot of the accelerated change in healthcare, not all of it by a long shot, but a lot of it has been due to regulatory activity associated with the Affordable Care Act and other priorities of the Obama administration, like expanding access to primary care. Not exclusively, to be sure, but federal engagement in healthcare, through regulatory activity, was a significant contributing factor to driving change in health care. So now, going forward, we are again seeing new complexity, no surprise, introduced into healthcare. But this time, it'll be driven a little bit differently. It will be driven by a result from shifts away from the trajectory that began seven years ago. A different orientation toward regulatory activity, as I said, isn't surprising. But from my experience, there are two features of this new change, or this change in administrations, that I think are a little bit different and merit highlighting. One difference is the breadth and depth of regulatory change underway now. In my 30 years of working in health policy, in and around it, the orientation to rolling back regulations that are currently in place is unparalleled. I can't really think of another time when that's been such a strong focus. And so, over the next few years, I would suggest, it's probably pretty likely that when regulations are promulgated, they will be fewer and they'll probably be more narrow than they were during the Obama administration. So tracking on health care changes from regular federal regulatory activity now and over the next few years, should focus on new regulations that are promulgated, of course, but paying close attention to the impact on health and health care of regulations that are repealed. That is really going to be important because that's where a lot of the regulatory focus is now. And that brings me to my second point about why this change in orientation is relevant for you. And that has to do with the opinions of the public and policy makers about the usefulness of regulation and regulatory activity and this administration's efforts to alleviate regulatory burden. And currently, congressional leadership conveys somewhat the same
orientation toward regulatory activity. To illustrate this point, just last month, the Chair of the House Ways and Means, health subcommittee, a very powerful committee when it comes to health, which perhaps you know, the Chair announced last month the creation of the "Medicare Red Tape Relief Project," which focuses on reducing regulations in the Medicare Program. You get a sense of the subcommittee Chair's opinions about the value of regulatory activity from that title, don't you? Red Tape. Red Tape doesn't have a very positive connotation for most folks, most of the public. So the subcommittee Chair has indicated that the intent of his initiative is to scale back existing regulations that impact physicians and that impact hospitals after they've taken in public comment. So again, sharp contrast to the administration in its current leadership, both from the executive branch and also from Congress, the legislative branch of the federal government that have been fairly visible in calling out the harm that can come from over regulating. And that harm that they believe has been caused across different sectors. So why is that important? At least, think a little bit about because how regulatory activity is discussed is relevant. It can impact the public's views about the value of regulatory activity. In other words, the value of your work and the way you go about it can be affected by how regulatory activity is perceived. Sometimes described in really stark language, can be something as different as, "Regulations are crushing and burdensome," to, "Regulations are consumer-oriented and protective." The point is that now that we've got a different focus on regulatory activity and a different tone, potentially, around regulatory activity, while it's always important to be sensitive to what the public's perspective might be, it's probably even more important to pay a little closer attention to that now. To the regulatory climate in your own state, with an eye toward whether or not that climate, that attitude about regulations, changes. Related to this, one of the regulation 2030 concept maps highlights outreach and specifically notes, "Public familiarity with the board of nursing’s role and function and improved public perception and trust of nursing boards." In this environment, it's probably worth paying a little extra attention to how you frame your work in ways that really help to communicate, to both the public and policymakers, the impact and benefits of your regulatory efforts. So the first takeaway this morning of the five that I'm going to share is this. This year, and at least for the next few years, the focus of regulatory activity at the federal level is markedly changing. No surprise, that's what happens when administrations turn over. This time, though, it will be in particularly important to pay attention to changes in health and health care that are a result, not just of the introduction of new regulations, but of a lot of activity of regulations that are being revised or repealed. And boards of nursing should pay even closer attention to state, public, and policymakers views regarding regulatory activity. To ensure that the public and the policymakers understand the value of your work, you may even want to think a little bit about and through the approaches that you use to frame the importance of your work. And to consider engaging perhaps even with other regulatory bodies to identify those best communication strategies that can help clearly explain and underscore that value. So that's the first takeaway. With changes in the regulatory environment in mind, let's turn to some of the changes underway in healthcare and consider what is driving them and the importance of partnerships as you engage your work in this very dynamic environment. In broad terms, we can think about two drivers that are accelerating change in health care. First, changes are coming from a rapid acceleration in new opportunities that can be leveraged. Secondly, changes are coming from health care opportunities, from opportunities that can be leveraged. Second, changes in healthcare are coming from, excuse me, are coming from efforts to address serious problems. So first change is driven by opportunity, second change is driven by efforts to address problems, serious problems in healthcare. Let me say a word about each. In terms of leveraging opportunities, I'll share just one example. It's well known to each of you, although its form and its application is changing almost constantly. And that is the rapidly expanding availability of new technology. Even helping to create virtual hospitals and care centers with hundreds of nurses,
physicians, and other staff, located in brand new buildings, delivering health care but without a patient in sight. At least on the site. You'll be hearing more about that through your meeting. So changes as a result of leveraging opportunities. Using this example, changes from technology. Other changes in healthcare and health policy, though, fit in that second category that I mentioned. They're changes in healthcare in response to very serious problems. These are problems that are fairly narrow in scope or problems that are overarching and they can impact a large swath of healthcare. Serious changes that have a narrow or more targeted set of changes to address them are, for example, specific health problems. Like the response to the opioid use disorder. That serious healthcare problem is driving changes in the parameters around training and prescribing, for example, for nurse practitioners and physicians, among other changes. But there are also broad, overarching problems where the solutions for them will impact many factors of healthcare. For example, the health status of U.S. citizens. Just last month, the Commonwealth Fund released a study looking at key health-related indicators of 11 high-income countries. And by the way, for those of you that are not on the Commonwealth Fund listserv, I'd encourage you to go there, look at it and maybe even sign up. Because they push out no-cost, high-value policy briefs on national and international trends in health and health policy. But back to their study that they just released last month, where in the health status rankings of those 11 high-income countries, would you guess the United States ranked? Where? I heard the word, "Last." So whoever I heard that from, you are right. So U.S. ranks dead last. Our citizens, while we lead the world and while we spend on health care, across high-income countries, our citizens are sicker and more likely to die than people in 10 other high-income countries. That is a broad, big, overarching problem. And those deaths that I just mentioned, those deaths are largely related to preventable conditions. So what do we have? We have high costs and subpar health outcomes that are unacceptable, overarching problems that are driving new programs, new policies, new care models. So thinking about the drivers of change in healthcare, changes that happen in response to problems and changes that happen in response to opportunities. Thinking about changes underway, driven by these two categories, allows you, boards of nursing, to think about and also consider the role your work plays, related to either emerging opportunities and leveraging them or being part of the solution to narrowly-focused problems or broader problems. For example, in terms of challenges, could information about policy and regulatory infrastructure from the other 10 countries, the other 10 high-income countries that I mentioned with better outcomes, could that be a place to look for identifying potential regulatory improvements that might inform our regulatory work here in the United States and could potentially have an impact on people's health status here? What about the role and function of nurses in those other 10 countries? Something to be learned there. The NCSBN's global regulatory atlas that is due to be released this time next year, might be a resource to begin to explore those questions from a regulatory and a nursing practice perspective. And when it comes specifically to healthcare quality and patient safety, which your work very directly affects, there are a number of dynamics poised to change that part of healthcare as well. And I want to mention just a couple. First, as the complexity of healthcare increases through broad changes underway, not all changes that are being developed, not all changes that are being implemented in the healthcare system, in policies, or in programs, not all of those changes are designed to optimize patient safety. In fact, some are designed, of course, to improve access to care. Other policies and programs are designed to impact the rate of growth in spending and bend the spending curve down. But even changes in these areas, unintentionally, can impact safety and what nurses do. Also, driving change in care quality and safety are newly developing capacities in health care research. Capacities that allow researchers to mine very large data sets, to conduct research more efficiently and to more quickly incorporate evidence into healthcare decision-making. In fact, in this next era of regulation, research findings will inform shifts in the boundaries around the roles and functions of specific healthcare disciplines, like nurses, pharmacists
and others. And research findings will also shift boundaries around the functions of the healthcare sector itself. These changes will come faster, as a result of an increase in sheer volume of information. To give you just one example of this dynamic, the Centers for Medicare and Medicaid Services is now giving access to their regional and nationwide claims data with hundreds of thousands of data points in those files that's being made available to institutions for commercial use and for other uses for that data. De-identified, of course. But large data sets that are being made available. This and other big data research capacity being built now, like the Precision Medicine Initiative led by NIH, will quickly generate volumes of new information that directly and indirectly touch the work of virtually every facet of healthcare, including the nursing profession. And so it will impact your work too and that impact will be on an accelerated timeline. Historically, do you know that it has been estimated that the time it takes for a new research finding to be embedded across healthcare delivery is about 17 years on average? Think about that. Historical estimate. In this new era that we are entering, expectations will be the doctors, nurses, health care systems, and others, apply newly derived information and knowledge much faster than their predecessors. In other words, new information will flow in minutes and months, not in years. And new evidence-based health care changes can have implications for everything, from what new graduates are tested on in licensure exams and in academic programs to implications for the parameters around relicensing. Going forward, the timeframe that regulators, academics, health systems, and others will have to respond to new knowledge and to incorporate it. That timeframe will not be on our side. It will not be a 17-year-average to adjust features of health care delivery and regulation in response to new knowledge. There is a thorough and well-done paper, produced by the University of Pennsylvania's Law School, which if you haven't reviewed it, I think it's worth a perusal. It is titled <i>Listening, Learning, Leading. A Framework for Regulatory Excellence.</i> This report points out that part of what makes achieving regulatory excellence so difficult is the complexity of challenges. Well, the healthcare environment, as every one of us knows, is a highly complex, increasingly dynamic sector with a plethora of access quality and cost related opportunities and challenges. Against this backdrop of complexity and transformation in health care, navigating and influencing healthcare quality and safety will continue to be a focus. But it's a focus that will continue to be shared by many different stakeholders, including accrediting organizations, other state and federal regulators, payers of healthcare, like insurance companies, state and federal policymakers, health systems, as well as organizations that represent the public's interests in safe, high-quality care. In other words, your work. Your work as regulatory boards will continue to be one part of a complex multifaceted enterprise that has a wide range of stakeholders with varied responsibilities for, and interests in care quality, interest in provider competence, interest in patient safety. And related to this, that Penn State report that I mentioned makes a pretty interesting observation, particularly given their expertise and regulatory activity. They state quite unequivocally this. They state that the success of regulatory bodies that operate in complex systems is ultimately defined and shaped by their interactions with others. Success defined and shaped by your interaction with others. In a transforming healthcare environment where there is so much need for improvement and so much opportunity for innovation, with such a large number of stakeholders with shared interests, siloed efforts that are disconnected from other key players are even more likely to lead to fragmentation, inefficiency, poor coordination, and initiatives that are neither robust nor fully informed. And so across healthcare, you know, it really is no surprise that there are more and more calls for collaborative efforts which is increasingly viewed as a critical way of doing health care and health policy business. In fact, collaborating around key initiatives and forming partnerships to improve health and healthcare are strategies that are viewed as essential to advance health agendas from national to international levels, from the World Health Organization, to the International Council of Nurses, to leading U.S. Think tanks. All opining on the importance of collaboration and partnership to advance health agendas. In other
words, this view about the need for collaboration in healthcare, it's a view that is widely shared. I'll give you just one example of this view, coming from a very high visibility organization that has recently commented on the importance of collaboration around healthcare and health policy. The organization, the National Academy of Medicine, historically referred to as the Institute of Medicine, which serves as an advisor to the nation and to the international community. It does its work by focusing on critical issues in health and related policy. In their recent report, <i>Vital Directions for Health and Health Care,</i> they assemble evidence-based strategies for advancing healthcare. And do you know what else they do? They specifically speak to the shortcomings of trying to advance important health-related work with only limited input. They are highly critical of silos that exist across disciplines and sectors and they point out how counterproductive that is to making progress forward in health care and health policy, particularly when it comes to developing needed innovations. The report talks about collaboration as a prerequisite to achieving much needed innovation in health care. Simply put, given the dynamic that we are operating in, collaboration isn't just a nicety. With increasing frequency, it's a necessity. To draw on an analogy, as a journalist said about the European Union when it was first forming, he said this, "We all share the same sky. We just have different horizons." When it comes to care quality and ensuring competency of providers and the delivery of safe care for patients, many stakeholders share that collective sky. And it's critical to understanding what they see on their horizon and how they are planning to react to it, in order to ensure and strengthen alignment across stakeholders and to fully leverage all of these assets to benefit patients. So the complexity and transformation of healthcare is increasingly viewed as driving the need for policy makers, including boards of nursing and others in health care, to assess for opportunities that would benefit from strengthening and creating collaborations and partnerships, not only to more effectively respond to changes underway and to manage through uncertainty, but also to shape those changes as well. In thinking about assessing for opportunities, in preparation for today, I looked at NCSBN's strategic objectives associated with your four strategic initiatives. And it's clear from what you intend to accomplish, that layering in expertise and buy-in that comes from establishing meaningful partnerships could be critical to fully achieving the initiatives that you have laid out. Whether the focus is on strategic objective number 7, developing a North American Compact for Telehealth, or strategic objective 11, identifying and promoting behaviors that transform how boards define and accomplish value-added work to lead and to respond in this era. Whether it is to solve problems or to integrate important new initiatives like a broader Telehealth compact, it is increasingly important to introduce more expertise and more knowledge than what resides in any one stakeholder. So let me summarize the second takeaway this way. While partnerships and efforts to collaborate on initiatives have always been strategies in your toolbox, the pace and complexity of healthcare transformation and a significant need for innovation to address really thorny problems in health care, that is driving the need for more meaningful collaboration. And this is even more important in areas like patient safety and quality. Because interest in and expertise and responsibility for quality and safety reside across a wide array of stakeholders, many of whom have significant new priorities and activity underway. This brings me, then, to the next major point. The University of Pennsylvania report that I referenced earlier, talks about the source of regulatory excellence. And the authors suggest that regulatory excellence comes from strengthening your ability to solve problems in ways that deliver greater impact. So how does one determine whether a partnership approach will strengthen your ability to solve a particular problem or to leverage a new opportunity? Well, in answering that question, let me take one idea or one option right off the table. Based on my experience working in health policy now for over three decades, whether or not to partner with other stakeholders, that's not a function of the size of a new initiative or the size of a problem to be solved. It is a function of the focus of the initiative. It is the function, based on my experience, of the nature of the problem. In other words, partnerships can bring
value to narrowly targeted efforts that engage a small number of partners as well as bring value to the pursuit of broader, more encompassing goals with multiple stakeholders. With this in mind, there are a small set of questions that when I worked at the Health Resources and Services Administration, when I led that part of HHS, and then, in the front office of HHS, when I worked as the Acting Deputies Secretary, I had a small set of questions that I used to help me, personally, sort through when to reach out to stakeholders. And I want to share that small set of questions with you. If you don't already have a standard frame to use to make that determination. Whether your work is at the state level, national level, or international level, then these questions, if you don't have a frame, might be helpful to you. They're straightforward and they sound simple, but let me tell you, my view, from my experience, they merit robust consideration. So here they are, to help you determine whether to engage partners. The first question, number five, is this. First, who has a stake? Who has a stake in this initiative or in solving this problem because of the focus of their work? Who has a stake because of the focus of their work? Second, who has a stake in this initiative or in solving this problem because of their expertise? These two questions are not the same, as examples that I'll give you shortly will illustrate. The third question to ask, what do you want to achieve from a partnership with each potential stakeholder? That is, what are your expectations? What is the purpose of engaging a stakeholder? What is the value add? And let me tell you, you need to be very clear in your answer to that question about what you want to achieve from that partnership. And also very important, the fourth question, what will the stakeholder achieve from the partnership? What will they achieve from partnering with you around this initiative? In other words, what's in it for them? There might be high return on investment for a particular partner or that return on investment could be negligible. They may well be willing, however, to participate in either circumstance. But it's really important to have thought through what the likely value will be that will accrue to a potential partner as a result of their participation. And the last question. When you expect that you're going to need some sustained collaboration, that is this is not going to be a short interaction, when you expect this will be a longer-term engagement with partners over a period of time, here's the question that needs to be asked in that circumstance. What are the temporal benchmarks of success associated with the effort? In other words, what are the indicators along the way that will convey to you and to your partners that progress is being achieved? We have all been part of efforts, collaboratives, that may have had a clear goal to the work, but where there is no clarity in or accountability for progress to achieve that goal. And that is often when you start to see drift and reduced participation. The CDC, the Centers for Disease Control, has a useful publication titled Partnership Programs. And that publication talks about structured approaches to building, not just partnership, but building partnership programs. It might be worth reviewing that publication because it devotes some narrative to the importance of keeping the focus on measuring progress during a partnership. On the face of it, as I mentioned, these questions, they're straightforward, but they actually do require careful consideration. And if you do that, the answers you arrive at will help you to determine whether to engage a partnership strategy around a particular problem or around a particular initiative. Making a determination about whether to engage stakeholders in a collaborative effort and being clear about the value you expect that partnership to generate, this should become a standard business practice within your organizations as you work to solve particular problems or as you leverage into new opportunities. In other words, methodically reviewing standing partnerships that you have and scanning for new partners against the work that you set out to accomplish, the process for doing this within your organizations, that process should be routinized. As regulatory bodies in healthcare, you do need to be deliberate about creating opportunities to share knowledge. To engage with stakeholders around plans of work, you do need to be deliberate and thinking about how to leverage expertise around common agendas. Let me illustrate just some of these points in action, through two examples. The first example reflecting on a national
practitioner data bank collaboration with NCSBN while I was leading HRSA just a few years ago. During my time as the HRSA administrator, I was responsible for over 80 different programs. One of them was the National Practitioner Data Bank. For a period of time, I spent a fair amount of effort working with our NPDB staff on their program because I came to learn that we were not fully in compliance with a specific statutory requirement around reporting and a couple of other related issues. For me personally, as a fairly new administrator in the administration, it was one of those, "Houston, we have a problem," moments. Using my earlier metaphor, while NPDB and NCSBN have different horizons, we've certainly shared the same sky and it was clear that NCSBN was a valued partner inside HRSA. You were trusted. So NPDB staff approached NCSBN to work collaboratively to address the problems that I just alluded to. Though that collaboration was not without struggles, collaborations are not by their nature easy, that collaboration was not without struggles. However, we had a clear aim, we had a clear aim of improving compliance with NPDB programs and program requirements across the states. This work involved efforts to compare your adverse actions in nurses with our data. And with clearly articulated aims and outcomes, working together, we eventually got there. With these organizations' work together on common data elements and definitions of licensure actions, NPDB and NCSBN partnered to achieve challenging, but really positive state reporting and compliance with reporting to the databank. And also, they worked together to overcome some large data issues. And our partnership around sharing expertise was reflected in your inviting NPDB to participate and actually present at annual meetings and your willingness to meet with NPDB staff to educate them on how the state boards and NCSBN functions. This may sound perfunctory, this may sound like sort of a throwaway. That is inviting a partner to educate you on their role in functions, but it isn't perfunctory. It isn't a throwaway. It is incredibly important. Aligning the efforts of stakeholders to work together on shared agendas, it cannot happen if prospective partners don't have a very clear and contemporary sense of the purpose, the current priorities and the expertise of their colleagues, of other partners. Looking forward, while I can no longer speak, I no longer speak for NPDB, I can tell you this. That while I was at HRSA, we worked to strengthen our research and analytic capacity within that program. And in that agency, I believe that the partnership between NCSBN and NPDB in research analysis, going forward from right now, going forward, has much greater potential than perhaps has even been mined to date. And that research agenda between the two organizations could be even further strengthened by dealing in one more organization, the Agency for Healthcare Research and Quality, AHRQ, to pursue informative work, such as assessing state laws and associated trends, and sanctions, and reinstatements. From NCSBN's vantage point, in the consequence maps, in the concept maps, you specifically mention NPDB involvement tied to national and international task force on discipline processes, along with research agendas that test policies to determine the impact of disciplinary actions and remediation efforts. Any one of these organizations, you, NCSBN, NPDB, or AHRQ, operating in isolation has limited resources and expertise and, as such, can provide only a piece of the policy and research picture. But through data analytics and possibly even data sharing and given the intersection of shared interests and expertise, the stage, I think, is really set for further advancing your collective work. NPDB's work, NCSBN's work, and AHRQ's work, in a much more vibrant way, to make a broader contribution to patient safety than any one entity could do on their own. And based on my experience, you've built a foundation for it, having developed a trusted relationship. Trust really is absolutely essential. It's an essential underpinning of partnerships. At times, the processes that we're obliged to use in government, they don't always lend themselves to full transparency all the time. And so they don't always lend themselves to being supportive every minute of trusting relationships. Because by their very nature, there are some decisions and related internal review processes that are held close to the vest, until announcements can be made, regulations are released publicly and so on. I had to make many phone
calls while working in government that I knew were going to result in disappointment to important stakeholders with whom I worked. But the fact that we had collaborated together on specific initiatives, that went a long way toward building a foundation for future engagements and keeping doors to communication open. The second example that illustrates the power of collaboration to achieve big ambitious goals is this. When I was at HHS, our broader HHS team was involved in investing in quality improvement across the nation to improve care. One of the efforts created was an initiative called "Partnership for Patients." Any of you hear of it? "Partnership for patients." P4P for short. Well, some of you might actually have even participated in it. Through this effort, we focused on achieving identifiable, quantifiable outcomes in improving patient safety in hospitals. There were explicit, big, quantifiable goals set, focusing on problems like reducing preventable hospital acquired conditions, such as pressure ulcers and surgical infections, surgical site infections. Clearly, HHS is a big player in healthcare. But we weren't in hospitals and we certainly didn't have all of the needed expertise to achieve high-priority safety goals. So we could have taken an easier path and just focus solely on what we, at HHS, did control and put all of our efforts into that, to that kind of a safety initiative. But we knew that we would result only an incremental change when what was really needed was sweeping impact to save patients lives, to prevent injuries, and to hold down unnecessary spending associated with events like preventable readmissions. So the partnership for patient safety was formed. Rather than operating solely, the HHS reached out to operate collaboratively. The partnership successfully generated unprecedented results through a shared agenda, crafted, executed, and evaluated, through collaborative public and private work. You know, we had a wide range of private partners working with us, including states, healthcare providers, payers, employers, healthcare researchers, providers of continuing education for health professionals, and patient groups like the March of Dimes, labor unions like AFL-CIO. And we also had, within HHS, Medicare, Medicaid, HRSA, CDC, and others too working on this shared agenda. The strength of this effort, of partnership for patients, the ability for us to achieve our aims came from leveraging expertise and generating alignment around shared goals. It was a heavy lift. It was a heavy lift to build that collaborative effort. And it is likely obvious to you that as I read that list of participants to you just now, not all of those stakeholders that I mentioned, you probably might have picked up, not all of them see eye to eye on all health issues. They don't. This is a good example of being open to working together even if you and a potential partner, historically, have had disagreements. Even serious disagreements on other issues. For example, some state boards of medicine and nursing have had some of that history. Disagreements on issues like scope of practice. But as I learned working on Capitol Hill many years ago, an opponent on one issue may be an ally on another issue. So you burn bridges only if you know you will never need to cross that bridge again. Also, there are side benefits that can result from bringing partners to the table. Working together on a shared goal can build a foundation for better communication and relationships in future interactions. I alluded to that just a moment ago. Secondly, though, we are almost always better off when stakeholders have been part of our work and, as a result, understand our values and understand our goals. Because partners can become advocates. And whether they are nursing associations or some other stakeholder, they are often in positions to express views that people working within government are just not able to do. In terms of the Partnership for Patient initiative, ultimately, this partnership generated major national results. I'll share just one of those results with you. P4P saw an 18% reduction of adverse drug events in participating hospitals. Not 2%, not 10%, but an 18% reduction in adverse drug events. This multifaceted partnership had clearly stated goals, it applied evidence about harms and how to reduce them, it created public/private partnerships that stood up, vibrant communities of practice, and through that, leveraged shared expertise. What this illustrated was that partnering with stakeholders, we could achieve major reduction in patient harm, a goal that many of the stakeholders were aiming for, but too often, we aim independently from each
other. So the third takeaway, as you plan for your work, considering whether to pursue partnerships with stakeholders should become a routine business practice within your boards. For executives in boards of nursing, time needs to be set aside to be thoughtful, so you can...about that. To be thoughtful about that, so that you can methodically think through that determination. Also, to be mindful that the size or scale of the issues you're focusing on isn't the determinant of whether or not to seek out a partnership with key stakeholders. Rather, what should determine that is the focus of the work that needs to be done to determine the benefits from establishing substantive stakeholder engagement around it. Well, with this orientation in mind, let's take a closer look at some of the considerations around selecting the who, around selecting who you might invite into partnerships with you to help advance your efforts. Clearly, the nature of a problem or opportunity that you're pursuing is what drives the selection of particular stakeholders, depending on the expertise that you're looking for. And each of you, no doubt, has certain partners that you are frequently reaching out to in order to achieve certain outcomes. Maybe it's the Board of Pharmacy in your state or the State Nurses Association, for example. But limiting your partnerships to other regulatory bodies, or to nursing, or even limiting your collaborative efforts to other stakeholders can be...well, it can be just that, it can be limiting. Partners that bring different experience and different perspectives can introduce innovative, fresh ways of thinking about strategies to address issues and challenges. Reaching outside of healthcare to build partnerships for change might help you to not just stay ahead of the curve, but actually, reaching outside of healthcare for partnerships might even help you create that curve. There are likely very content, rich, potential partners in each of your own communities and in each of your states that could help inform some of your work. But first, first you have to recognize the potential benefit. The illustration that I'm going to use to underscore this point is an older example, but it speaks to potential benefit, to creating the curve by engaging experts from outside of healthcare to help find new ways to address serious problems inside healthcare. Over 15 years ago, two reports, *To Err is Human* and *Crossing the Quality Chasm*, were produced by the Institute of Medicine, now called the National Academy of Medicine. These reports triggered a cascade of concern from policymakers, the health sector, and the public. The reports prompted new policies, new programs, and new practices that have been rolling out ever since. Well, what was it that was so striking about those two reports that set them apart from virtually any other report that the National Academy of Medicine had produced to date? It was this. Those reports shared research indicating that thousands of patients' deaths were resulting not from their illness. Those patient deaths were resulting from medical error. And that there was widespread and serious shortcomings in the quality of care delivered in the United States. The narrative could not have been clearer that too often, people who were seeking help were being harmed. As with all National Academy of Medicine reports, there were also recommendations about what to do to address these complicated issues. The visibility of the reports was so high, in fact, that it spilled outside of this country's borders and, ultimately, informed thinking in other countries as well. Some might think that the ideas embedded in those reports and the content and the recommendations was the sole product of the committee members. It's true the committee members, included, at the time, some of our giants in patient safety. Lucian Leape, Don Berwick, among others. But even with some of the best expertise from inside health care, some of the best expertise in health care safety at the table, many of the recommendations and innovative approaches to addressing harm and strengthening safety came from experts and partners outside of the healthcare industry. Their expertise strengthened our ability to propose innovative solutions that delivered far greater value to improve care quality and patient safety than would have been the case had we not sought that benefit from outside experts. Through our collaboration with those external stakeholders, we found new ways, fresh ways, to approach serious and sometimes deadly safety problems in health systems. For example, educating students in teams because they would be working in teams and the
importance of situational awareness and the importance of removing power gradients, so that everybody in a health care environment feels empowered and obliged to call out potential safety compromises. In other words, some of the most substantive ideas incorporated into those two reports that built out part of a new foundation for safety and health care, were based on what we learned from experts from outside of the healthcare industry. In fact, we drew on disciplines and experts that were about as far removed from health care as you could possibly get. We drew on and we partnered with experts from aviation. We partnered with experts from the banking industry to better understand safe and secure electronic information transfer and so on. And the value of reaching out over 15 years ago to understand and incorporate that external thinking came home to me again just last year. Last year, I was at an international conference in London, attended by health ministers from 8 different countries and I was there representing the United States. The conference focus working across country borders, applying lessons learned from other industries and other countries to further strengthen the capacity to deliver safe patient care. So who we engaged in the work of patient safety improvement and who we learned from then, had a ripple effect, not just across hospitals and healthcare in the United States, but across other countries too. So the lesson here, when boards of nursing consider potential partners to advance your work, particularly now when we often need new ideas to respond to thorny, emerging challenges, there should be a deliberate effort to think about, to consider partners from outside the health care industry, perhaps from commerce, from education, from transportation, to harness ideas that can improve the value of what nurses do in health care and how we do our work. Even how you, as state boards, do your work. One other example to give you a sense of what can be accomplished by looking outside of healthcare. At HRSA, one of the 80 programs, the other 80 programs, within that agency is the organ donation and transplantation Program. When I was with the agency, we worked...through the organ donation and transplantation program, we worked to find better ways to move organs more quickly, given the fairly quick turnaround that needed to occur, particularly with certain organs like hearts. Organ transportation isn't itself done by HRSA, but we support transporting organs through the work that's done, through organ transplant networks and by hospitals across the United States. However, from HRSA, we could see an opportunity for improvement in transportation of those organs system-wide. So we pursued expertise. Where did our expertise come from? We pursued expertise from outside of healthcare. Any ideas about where, if you were sitting at HRSA, you might have looked to address a problem like this, that is more efficient transportation of organs? Think FedEx. Think FedEx. Think FedEx. So what did we do? We reached out to FedEx. We reached out to FedEx. We decided to collaborate with them to bring on one of their experts to work with us, to help us improve processes that would get the right organ to the right location, in the right time frame, every time. Because any organ wasted could translate to a life lost. FedEx transportation processes brought to bear on organ transplantation. Being comfortable with and learning from others that are willing to share their expertise with you, even from outside of healthcare, is really important. In fact, the University of Pennsylvania document that I referenced earlier, makes a similar point when they note that a regulatory organization with a culture that values learning and that reinforces learning is more likely to achieve greater levels of competence in their work. Well, as you think about the opportunity to learn from and to work with other partners, think about partnering too from outside the healthcare sector. And if you do, there are two simple, again, and straightforward questions that merit thought, that merit discussing. Let me share those two questions to help you think about partnerships outside of organizations, that you might ask yourselves as you do this work within your boards. The first question is this. "Looking outside of the health regulatory and the healthcare environment, are there individuals, organizations, sectors that could inform your thinking about the initiative or the problem that you're working on?" That's the first question. And the second, "How could their knowledge, how could their expertise benefit your work?" It
is not such a stretch to go from identifying that human organs could be wasted because of clunky processes in transporting them, to thinking about UPS or FedEx as a potential partner in designing innovative transportation process improvements. But the first hurdle to get over is to recognize that expertise and innovative ideas, they can come from people who know virtually nothing about regulation or about healthcare. Engaging with stakeholders and innovating means moving out of your comfort zone and sometimes taking risks. For example, asking to learn from colleagues in an entirely different industry and seeking help to apply their knowledge to your work to ensure the delivery of safe, competent nursing care. So the fourth takeaway, innovative approaches and substantive achievements can be outcomes of collaboration that draw partners from outside of health care to improve what is going on inside health care. Boards of nursing should be deliberate in assessing where their partners from outside of traditional stakeholder groups could in fact bring value to the work that you do. This brings me to the fifth and last consideration. As you know well, the work that nurses do to improve and maintain health is no longer confined to the bricks and mortar of traditional health care delivery systems. For example, confined to hospitals, or confined to clinics, or confined to traditional public health. This is due in part to the fact that the knowledge we have about factors that influence health, that knowledge, what we know about factors that are influencing health, that knowledge is changing. There is increasing recognition that the health status of individuals and communities is significantly impacted by circumstances outside of health systems. This expanding knowledge makes boundaries around nursing practice even more porous because it can create opportunities and even new expectations for nurses and other health care providers to work in new ways and focusing on new health-related issues. In the United States, for example, a steady accumulation of data over the last 10 to 12 years has provided robust evidence around social determinants of health, such that now, more of this evidence-based content is being taught in medical schools, being taught in nursing schools and in other health profession schools too, for that next generation of health care providers to consider and to act on. And health policies and programs are following suit. For example, at the Health Resources and Services Administration, we invested over $1 billion, 1 billion, with a B, dollars in home visiting programs. Home visiting programs which put nurses and others squarely in the middle of working on social determinants. Like facilitating early education of children or supporting job skills for new moms. The evidence documenting the positive impact of these home visiting programs like the Family Nurse Partnership Program, that evidence could not be more clear. But what does this mean for nursing’s role? It has meant that to meaningfully impact health of vulnerable families, there is a blurring, if you will, of the traditional boundaries. There’s a blurring of the boundaries between health services and social services and working across those boundaries. In other words, nurses knowledge and their associated actions taken by nurses, ultimately, to prevent health problems, is more about a patient's ZIP code than it is about their genetic code in some circumstances. Within the shifting focus of nursing practice toward the delivery of social and other services and away from the delivery of traditional nursing services inside the bricks and mortar of traditional health care settings, from a regulatory perspective, what does that nursing competence look like? What does scope of practice look like? This isn't the traditional scope of practice question of nurses versus physicians, for example. This is a scope of practice of nursing in the context of new evidence, new opportunities and need, driven from outside of traditional health care. And going forward, as more information accumulates about characteristics that affect health, the boundaries of nursing practice may become even more murkier. To consider potential new practice parameters requires partnerships with experts knowledgeable about those other areas. Let me share a second example that illustrates the reshaping of practice boundaries. And as I briefly talk through this one, I'd ask you to think about implications for your work, for your programs, and for your policy initiatives. And consider too the possible stakeholders that could be good partners in supporting your efforts to
About two years ago, the United Nations General Assembly adopted 17 Sustainable Development Goals to address serious and pervasive global problems by 2030. Goals like aiming for zero hunger and aiming for quality education. And each of the goals, the 17 goals, has a set of strategies, targeted strategies to help achieve those 17 goals. Here's what's important for all of us to know. Almost every one of those 17 goals that comprise the Sustainable Development Goals, almost every one of those 17 goals address problems that have been found to put the health status of people around the world at risk. Almost all of them. Consequently, work to achieve those goals helps to prevent health problems and, of course, preventing illness is a big part of the work of the nursing profession. So just as Telehealth is reframing how and where nurses and other clinicians do their work, the SDGs, the Sustainable Development Goals, are an example of reframing what nurses and other health care providers might focus on. So the question is this. Are there implications for regulatory frameworks that need to consider and perhaps adapt to keep pace with changes in the what of nursing practice? Let me put a finer point on this by citing two of the 17 SDGs.

One of the Sustainable Development Goals focuses on eliminating poverty. The connection between the relevance of poverty to nursing practice, frankly, is as straightforward as nurses working, not just to respond to health problems caused by poverty, but also from a prevention perspective, helping people to get out of poverty, avoid poverty in the first place. Clear, in the literature now, poverty can have multi-generational adverse impacts on health. And, of course, this isn't a problem just in other countries. Poverty is a problem right here in the United States as well. Living in poverty is a serious threat to the health and well-being of many individuals in our communities in this nation too. A second example is the SDG that focuses on the need for climate action. Nurses wouldn't generally be thinking about climate, probably with the exception of allergy seasons, for example, but now the science and some preliminary impacts of climate change are quite clear. Climate change is displacing entire communities and is also contributing to disease outbreaks that affect the health of individuals and communities. So climate science, plus nursing, plus health. Four words. Climate, science, nursing, health. You've probably not heard those four words in the same sentence as recently as even three or four years ago that you might have heard those words together. But the evidence base supporting the relationship between that problem and virtually all of the problems that the SDGs are designed to address are, as I said, found to impact health and that evidence then changes the way we think about and work to protect health. In fact, they tie into one of NCSBN's four strategic initiatives. To refine...excuse me. To envision and refine regulatory systems for increased relevance and responsiveness to changes in health care. So I ask you, what does nursing competency look like? What does nursing care competency look like? When that care focus is on, for example, achieving the SDGs. Care that is directed to preventing problems that largely sit outside of traditional healthcare delivery, but addressing problems that impact health. To assess the relevance of the regulatory systems to changes in nursing practice in the context of problems like the SDGs...those problems that SDGs, are designed to address, that requires engaging with broader global health entities, like the World Health Organization or the International Council for Nurses, and non healthcare sector representatives as well, all with the aim of seeking expertise in order to better understand the nature of this expanding work to improve health and to consider nursing's engagement in it. Of course, none of the 17 goals established by the UN that impact health are amenable to being achieved by just one professional group alone. None of them. Achieving these goals are contingent on people working across sectors collaboratively, including both health care and health policy arenas. In fact, the need for collaboration to drive this work forward is called out by both the World Health Organization and the International Council of Nurses. ICN points out that the health sector cannot do this kind of work alone in isolation and that nurses and other health stakeholders need to work with industry, with other government divisions and so on in order to address the problems that the SDGs
target. I mentioned the SDGs because they serve as an illustration of the porous boundaries around what nurses do and what nurses might do in the not-too-distant future and how their work is expanding, even into non-traditional air health arenas. This kind of change prompts questions to consider. What are the implications for a nursing education or for enumerating the supply of nurses through registration, given new practice boundaries? Are there implications for determining competence in these areas? How is the work of nursing boards relevant to these new practice parameters? And looking internally, are our regulatory environments and frameworks designed to accommodate this pace of change? Are regulatory processes, structures, and focus nimble and efficient when new areas of nursing practice emerge? So that brings me to the fifth takeaway, the last one. It is important to take stock of new knowledge and new challenges emerging from outside of health care, outside of the health sector, that, evidence shows is influencing health and health care. Some of these challenges and associated emerging evidence can change the contours of nursing practice and as such, they may well have implications for nursing regulation. So the need for nurse regulators to scan for development outside of healthcare that can impact healthcare is important. Just as it's important to track on changes inside health care systems too. This is important not just at global levels, but at state and national levels as well. Of course, it's complicated enough to navigate nursing regulatory work within the boundaries of your particular state, but in summary, everyday, changes are underway. Complexities are expanding in health care. Every day, members of the profession that you regulate help to reset the health trajectory for millions of people. Every day, the nurses...nurses rather, identify and solve myriad problems to improve health outcomes and they do it in the context of a web of expanding relationships and health care dynamics. So too, your work is increasingly nested in a broader pattern of working relationships and complex change. As we consider this new era of regulation, we can look back in history for one piece of keen insight. Maybe for many but I'll share one with you. In the 1800s, Florence Nightingale directly challenged nurses when she said this. She said, "Let whoever is in charge keep this simple question in her head. Not, 'How can I always do the right thing myself,' but, 'How can I provide for the right thing to be always done?'” Nightingale could very well have been talking about the work of boards of nursing. Your work to ensure the delivery of safe competent nursing care. In other words, through your mission to help provide for the right thing to always be done. This is the crux of what you do. In this next era of regulation that ushers in an increasingly complex world of regulation and of health care, to provide for the right thing to always be done and to do it well, is to do this critically important work that you do through partnerships for change. Thank you very much for the opportunity to be with you.